BILL ANALYSIS

Senate Research Center
89R27021 SCF-F

H.B. 3812
By: Bonnen et al. (Hancock)
Health & Human Services
5/19/2025
Engrossed

AUTHOR'S / SPONSOR'S STATEMENT OF INTENT

The 87th Legislature passed H.B. 3459 to address the growing issue of overutilization of prior authorizations for medical services by health insurers through the creation of a process by which physicians could earn an exemption from prior authorization requirements by attaining a 90 percent or higher prior authorization approval rate for a given service.

However, stakeholders have suggested the evaluation window for which services can be reviewed is too short and providers cannot reach the threshold for which they can qualify for a gold card. H.B. 3812 seeks to address these issues by extending the evaluation period from six months to one year, removing physicians who hold a license to practice administrative medicine as an individual who may direct a utilization review, and providing for annual reporting to the Texas Department of Insurance (TDI) regarding prior authorization exemptions.

H.B. 3812 amends current law relating to health benefit plan preauthorization requirements for certain health care services and the direction of utilization review by physicians.

RULEMAKING AUTHORITY

This bill does not expressly grant any additional rulemaking authority to a state officer, institution, or agency.

SECTION BY SECTION ANALYSIS

SECTION 1. Amends Section 4201.152, Insurance Code, as follows:

> Sec. 4201.152. UTILIZATION REVIEW UNDER DIRECTION OF PHYSICIAN. Prohibits the physician under whose direction a utilization review agent is required to conduct utilization review from holding a license to practice administrative medicine under Section 155.009 (Limited License for Practice of Administrative Medicine), Occupations Code.

SECTION 2. Amends Section 4201.651(a), Insurance Code, to define "affiliate."

SECTION 3. Amends Section 4201.653, Insurance Code, by amending Subsections (a) and (b) and adding Subsection (a-1), as follows:

> (a) Prohibits a health maintenance organization or an insurer that uses a preauthorization process for health care services from requiring a physician or provider to obtain preauthorization for a particular health care service if, in the most recent one-year, rather than six-month, evaluation period, as described by Subsection (b) the health maintenance organization or insurer, including any affiliate, has approved or would have approved not less than 90 percent of the preauthorization requests submitted by the physician or provider for the particular health care service and the physician or provider has provided the particular health care service at least five times during the evaluation period. Makes nonsubstantive changes.
>
> (a-1) Requires a health maintenance organization or insurer, in conducting an evaluation for an exemption under Section 4201.653 (Exemption From Preauthorization

Requirements for Physicians and Providers Providing Certain Health Care Services), to include all preauthorization requests submitted by a physician or provider to the health maintenance organization or insurer, or its affiliate, considering all health insurance policies and health benefit plans issued or administered by the health maintenance organization or insurer, or its affiliate, regardless of whether the preauthorization request was made in connection with a health insurance policy or health benefit plan that is subject to Subchapter N (Exemption From Preauthorization Requirements for Physicians and Providers Providing Certain Health Care Services).

(b) Requires a health maintenance organization or insurer, except as provided by Subsection (c) (relating to authorizing a health maintenance organization or insurer to continue an exemption under Subsection (a) without evaluating whether the physician or provider qualifies for the exemption), to evaluate whether a physician or provider qualifies for an exemption from preauthorization requirements under Subsection (a) once every year, rather than six months.

SECTION 4. Amends Section 4201.655, Insurance Code, by amending Subsections (a) and (b) and adding Subsection (b-1), as follows:

(a) Provides that a health maintenance organization or insurer is authorized to rescind an exemption from preauthorization requirements under Section 4201.653 only under certain circumstances, including during January of a year, rather than during January or June of each year, beginning on or after the first anniversary of the last day of the most recent evaluation period for the exemption.

(b) Prohibits a reviewing physician who makes a determination under Subsection (a)(2) (relating to if the health maintenance organization or insurer makes a determination on a certain basis that less than 90 percent of the claims for the particular health care service met the medical necessity criteria) from holding a license to practice administrative medicine under Section 155.009, Occupations Code.

(b-1) Requires the health maintenance organization or insurer, notwithstanding Subsection (a)(2), if there are fewer than five claims submitted by the physician or provider during the most recent evaluation period described by Section 4201.653(b) for a particular health care service, to review all the claims submitted by the physician or provider during the most recent evaluation period for that service.

SECTION 5. Amends Section 4201.656(a), Insurance Code, to provide that a physician or provider has a right to a review of an adverse determination regarding a preauthorization exemption, including a health maintenance organization's or insurer's determination to deny an exemption to the physician or provider under Section 4201.653, to be conducted by an independent review organization.

SECTION 6. Amends Section 4201.658, Insurance Code, to make a conforming change.

SECTION 7. Amends Sections 4201.659(b) and (c), Insurance Code, as follows:

(b) Prohibits a health maintenance organization or an insurer, regardless of whether an exemption is rescinded after the provision of a health care service subject to the exemption, from conducting a utilization review or requiring another review similar to preauthorization of the service, rather than a retrospective review of a health care service subject to an exemption, with certain exceptions.

(c) Makes conforming changes to this subsection.

SECTION 8. Amends Subchapter N, Chapter 4201, Insurance Code, by adding Section 4201.660, as follows:

Sec. 4201.660. REPORT. (a) Requires each health maintenance organization and insurer to submit to the Texas Department of Insurance (TDI), in the form and manner prescribed

by the commissioner of insurance, an annual written report, for each health care service subject to an exemption under Section 4201.653, on the subject of certain exemptions, determinations, and reviews.

(b) Provides that, subject to this subsection, a report submitted under Subsection (a) is public information subject to disclosure under Chapter 552 (Public Information), Government Code. Requires TDI to ensure that the report does not contain any identifying information before disclosing the report in accordance with Chapter 552, Government Code.

SECTION 9. (a) Makes application of this Act prospective.

(b) Prohibits a preauthorization exemption provided under Section 4201.653, Insurance Code, before the effective date of this Act from being rescinded before the first anniversary of the last day of the most recent evaluation period for the exemption.

SECTION 10. Effective date: September 1, 2025.